Chapter 14

HEALTH RECORDS

14.1. Purpose. The health record is a key instrument used in planning, coordinating, and evaluating patient care. In addition, the content and documentation contained in the health record is essential for education, research, administrative planning and accreditation.

14.1.1. Goal. The Health Record Service is to maintain and manage a health record system, which enables all health care team members to document and review all health care encounters and events. Office files are not considered to part of the official health record, therefore, all documents pertinent to the treatment and on-going care of a patient is to be forwarded to Health Record Services for inclusion into the health record.

14.1.2. Health Record Function. Each HSA will designate an individual from the Health Record Service to manage the health record system. The responsibilities include, but are not limited to the following:

XManaging the compilation of health records in an organized standardized health record format using the unit record system
XMaintaining the confidentiality, security, and integrity of the health record system
XEnsuring the availability and prompt accessibility of the health record to health staff
XParticipating in performance improvement activities and functions
XEnsuring the accurate and timely abstracting and coding of all diagnostic and procedural information indicated in all ambulatory encounters.
XEnsuring accurate filing, safe storage and prompt retrieval of health information and loose documents for patient care, research, release of information, legal, and performance improvement.
XEnsuring timely data entry of scheduled appointments and all encounter health care data into the automated health information system.

14.1.3. Equipment. Each facility will establish, maintain and support the Health Information Service with the following equipment, at a minimum:

XPhotocopier
XFacsimile Machine
XPersonal Computer and Printer
XElectric typewriter
XHealth Services Manual
XMedical Dictionary
XHealth Records Management (Edna Huffman, current edition)
XICD-9-CM Manuals (current edition)
XCPT-4 Manuals (current edition)

14.1.3.1. Health Information Practitioners. Credentialed health record practitioners are either registered or accredited by the American Health Information Association (AHIMA) and are qualified to manage and supervise the Health Information Service.

14.1.3.1.1. Registered Health Information Administrator (RHIA): Has a Bachelor's Degree in Health information Administration and has successfully passed the AHIMA's registry examination.

14.1.3.1.2. Registered Health Information Technician RHIT): Has an Associate Degree in Health Information Technology and has passed the AHIMA's accreditation examination.

14.1.3.1.3. DIHS Health Information Consultant: DIHS medical facilities with or without a RHIA or RHIT will have the DIHS Health Information Consultant evaluate the efficiency and management of the detainee health records and facility's health record system and make recommendations regarding the implementation of health information policies and procedures and conduct health information related training, as required. The DIHS Health Information Consultant will review conduct onsite reviews or indirect reviews through the receipt of facility reports, at least annually, or more often as deemed necessary. The DIHS Health Information Consultant will submit a written consultant's report as a result of each site review.

14.1.4. Accreditation. Health Records on each detainee are maintained consistent with applicable laws and in accordance with NCCHC, JCAHO, and ACA health care standards.

14.2. Security of Health Records. All health records will be maintained in a secured area separate from custody records. Access will be restricted to authorized personnel only. All personnel having authorized access are required to have received orientation and training in basic health record procedures, privacy and confidentiality. Areas designated for storage of active and inactive health records should have a sign visibly posted outside the entrance of the area indicating " Access Limited to Authorized Personnel Only".

14.3. Folder. The prescribed DIHS health record folder that has the preprinted DIHS facility information will be used to file patient health information. These folders are obtained through the following supplier:

PSC/DPM/PPMB
16071 Industrial Drive
Gaithersburg, Maryland 20877
Phone: (301) 443 – 7636
Fax: (301) 443 – 1227

14.4. Privacy and the Freedom of Information Acts. It has been determined by the Department of Justice and the World Health Organization that the guidelines and requirements as outlined in these two Acts will be applied to individuals in the custody of the INS. Under the provisions of the Privacy Act regulations (45 CFR, Part 5b) and the Freedom of Information Act (45 CFR, Part 5), detainees may access their health records and, upon written request, receive a copy of any or all portions of their health record, except information which might reasonably be expected to cause harm to the requestor or to another person while that detainee is in custody at the facility.

14.4.1. Statements of Confidentiality. Signed affirmations to protect and maintain the confidentiality and privacy of patient care information is required from all new employees who are employed in the medical facility and signed annual reaffirmation statements are required from each employee thereafter.

14.4.2. Privacy Act/FOIA Training. All new employees will receive training on the Privacy and Freedom of Information Acts within thirty days of reporting to the SPC and all current employees will receive annual refresher training within 30 days of the anniversary of their hire start dates. The training modules are available as hardcopy handouts or can be accessed through the DIHS website at www.inshealth.org.

14.5. Ownership of the Health Record. Health records may be removed from the medical facility jurisdiction and safekeeping only in accordance with a court order, subpoena, or direction received from the INS OIC or DIHS Director. All health records are the property of the INS.

14.6. Release of Information. The Health Information Service reviews and coordinates requests for accurate and timely release of information to assure continuity of patient care. The Health Information Service personnel are also responsible for the preparation of subpoenaed health records for submission to Courts of Law. Under the provisions of the Freedom of Information Act (45 CFR, Part 5) and the Privacy Act (45 CFR, Part 5b) detainees may access their health records. Additional questions or requests for additional clarification concerning the interpretation of these two Acts are to be directed to the DIHS Health Information Consultant.

14.7. Release of Health Information. The Health Information Service reviews and coordinates requests for accurate and timely release of information to assure the continuity of patient care. The Health Information Service personnel are also responsible for the preparation of subpoenaed health records for submission to Courts of Law. Upon receipt of a subpoena notification must be given to the HSA, Headquarters Privacy Act/FOIA Coordinator, and INS FOIA. Guidance will be given from Headquarters Privacy Act/FOIA coordinator on how to proceed with the subpoena. Under the Privacy Act, detainees may access and receive copies of their health records.

Detainee's can obtain copies of their health records by submitting a G-639, Freedom of Information/Privacy Act Request form to any staff member. The G-639 is to be forwarded to Health Record Services for processing. The health record of the requestor, the G-639 and the portions of the record to be copied flagged will be forwarded to the HSA or Clinical Director for review prior to release to the detainee. If the HSA or Clinical Director determines that the health record contains no information which may cause harm to the detainee, then Health Information Service may prepare the copies for the detainee. If it is determined that all or portions of the record should not be released to the detainee, then the detainee should be informed by the HSA, Clinical Director or designee of this determination and be provided the following options:

X The G-639 will be submitted to the INS Office of Regional Counsel, FOIA Office for a determination *OR*

X Complete another G-639 authorizing the medical facility to send the requested information to an outside third party

INS Regional Counsel's Offices:

Eastern Region: Office of Regional Counsel
FOIA Office
70 Kimball Avenue
South Burlington, VT 05403
PH: (802) 660-5043

Central Region: Office of Regional Counsel
FOIA Office/ADMIN Dallas-FFM
Dallas, TX 75247
PH: (214) 905-5276

Western Region: Office of Regional Counsel
FOIA Office
Attn: Renee Wolford
Laguna Nigel, CA 92607
PH: (714) 360-3039

14.7.1. Documenting the Disclosure. An administrative entry will be made by Health Record Service in the detainee's health record on the SF-600 stating that the disclosure was made, date of the disclosure, number of pages copied, inclusive dates and the nature of the information released. This entry will be signed and stamped as any progress note entry with the Clinical Director or HSA or designee co-signing the note to reflect concurrence. A notation will also be made when information requested is not released and referred to INS.

14.7.2. Filing the G-639. The G-639 is an administrative form to be filed in the detainee's health record under the Consent Forms Section.

14.7.3. FOIA Log. The bound FOIA logbook provides an accounting of each disclosure made based on requests received from detainees. The log will contain the following information:

XDetainee Name
XAlien Number
XDate Request Received
XDate of Disclosure to Detainee
XNumber of pages copied
XNature of the information released
XInitials of Health Information employee disclosing the information

14.7.4. INS Regional Counsel Offices. INS FOIA Offices are to be contacted when requests for health information are received from the following:

XRequests received from former detainees
XRequests from attorneys
XRequests from the media
XSubpoenas and court orders

When receiving requests from attorneys, the media and Orders from the Court, you will also contact DIHS HQ Clinical Operations Branch *prior* to responding to the request.

14.7.5. Disclosure without consent. Pursuant to the Privacy Act, provisions used as policy, certain disclosures may be made without the written or verbal consent of the detainee.

14.7.5.1. Sharing of information. This will exist between HHS, PHS and INS when it is deemed relevant for the health and treatment of the patient.

The following are examples of information disclosure that does not require consent by the detainee:

To an outside provider when a detainee is referred and/or transferred to another health care provider or facility, i.e. the USM 553 submitted upon the transfer of the detainee to a jail.

To an officer and/or employee of HHS, PHS or INS when the health care provider believes such information may be relevant to the detainee's health and course of treatment.

The medical director or his/her designee shall have access to information contained in the detainee's confinement record when they believe that such information will be relevant to the detainee's health and course of treatment.

INS staff may need to be advised of a detainee's health status in order to preserve the health and safety of the detainee, other detainees or staff.

14.7.6. Third Party Releases without detainee authorization. Requests from individuals outside the facility, such as attorneys, insurance companies, disability claims processors are considered third party requests. Third party requests not accompanied with a written consent are to be returned to the sender by the Health Information Service with a G-639 and state the reason(s) why the request cannot be honored.

14.8. Standard Health Record Practice. The identification, order of assembly and filing of health records will be done in a standard and uniform manner. The unit record and terminal digit filing systems are employed at all medical facilities and documentation is performed using the Problem Oriented "SOAP" format.

14.8.1. Health Record Identification. All health record folders will be identified with a label, which can be hand printed or computer generated. The label is placed in the upper right-hand corner of the tab projected out from the folder. The label will include the detainee's last name, first name, date of birth and alien number.

14.8.2. Health Record Folder. An approved DIHS health record folder is to be generated to file all patient health information when a health intervention with a health care provider has occurred, except for the following:

- Boarders.
- Stays Less Than 48 Hours.

14.8.3. Dividers. DIHS dividers SHOULD ONLY be used when a chart is voluminous. Medical records that have only a few forms do not require chart dividers.

14.8.4. Multiple Volumes of a health record will be marked with a white adhesive label located on the front of the health record in the right upper corner horizontal with the label containing identifying information. Example: Volume I of II.

14.8.5. Format for Recording Entries on the SF-600. The SF-600 is used to reflect the chronological order of patient care received from all providers and services received from administrative personnel. All entries on the SF-600 will be expressed in the SOAP format as follows:

XSubjective: the patient's description of the problem, symptoms in the patient's own words
XObjective: the information/data received from diagnostic evaluations and tests, etc.
XAssessment: the provider's interpretation of the subjective and objective data, evaluation of the patient's current health status and identification of problem
XPlan: specific course of action to include diagnosis or plan for further investigation to establish a diagnosis, treatment or plans for patient care and problem management and follow-up or schedule of return visits and/or referral(s).

Each problem will be assigned a number, which will be reflected on the Problem List and all other corresponding and related entries, tests and documents.

14.8.6. Signature Block. Health care providers and administrative staff who make entries in the health record will be issued a rubber stamp to facilitate authentication and identification of entries made in the health record. Signature stamps are <u>not authorized</u> for use in the health record.

14.8.6.1. Format for PHS Officers. The following format will be used for Commissioned Officers of the United States Public Health Service:

XPHS Rank (properly abbreviated)
XFirst name and middle initial
XLast name
XProfessional discipline

14.8.6.2. Format for Civilian providers. The following format will be used for Civil Service and/or contract staff:

XFirst name and middle initial
XLast name
XProfessional discipline

14.8.7. Health Record Content. The health record primarily serves the patient, however, it has many additional values to the health care team. The most obvious use of the health record is to document and review patient care encounters. Patient care providers rely on the health record as the principal means of communication and information exchange regarding patients under their care. All forms filed in the health record will be properly identified with the detainee name, alien number, date of birth and facility name. Each component of the health record must be authenticated (signed

or initialed and dated) by the provider. Health care providers must initial and date all ordered studies (i.e. lab, x-ray, consults, operative reports) as proof that the documents were reviewed.

14.8.8. Health Care Provider Entries. All entries will be identified and authenticated with the signature of the staff member and use of the rubber block stamp. All entries are to be legible using black ink only. No highlighter pens are to be used in the health record. Blank spaces are not to be left in the body of the entries, between entries or at the top and bottom of the SF-600. Corrections of recorded data in the health record must be made properly. At no time should incorrect information be obliterated from the record so that the information cannot be read. Obliteration of an entry would suggest tampering with the record.

A neat line should be drawn through the incorrect information with an explanatory note (i.e. error, wrong chart) and the date of correction and initials added to the correct entry.

14.8.9. Late Entries. A late entry is a notation on the SF-600 which was not made at the time that the service was provided or when the patient was seen. Late entries are to be documented as follows:

X"Late entry for (date and time).... The date and time of the entry should be the date and time that the note is actually made.

14.8.10. Entry on the SF-600. Patient visits, encounters and other patient related services (i.e. record review, release of information) will be entered on the SF-600 in the detainee's health record as follows:

XDate and time (military time to be used)
XProblem # (if applicable) SOAP note format

14.8.11. Abbreviations. DIHS Executive Council annually reviews and approves the standard DIHS abbreviation list to be used by all medical facilities. The use of medical abbreviations should be limited and only abbreviations from the approved DIHS abbreviation list will be used.

14.8.12. Consultant Entries. Recommendations made by consultants, which are approved by the Clinical Director or designee, are entered on the SF-513 Consultation Sheet and not on the SF-600. Approved recommendations will be transcribed by a DIHS provider onto the SF-600.

14.9. Filing of Records. Health records shall be filed in terminal digit order using the unit record system. The three part alien number is used to identify the patient. Records are grouped together first by using the last three digits of the alien number known as the Primary digits. Within each Primary section records are then filed numerically by middle (secondary) digits and last by first (tertiary) digits.

The following illustrates terminal digit filing:

14-652-202	19-605-264	27-798-307
14-752-202	19-905-265	27-898-307
15-852-202	20-605-266	28-898-307
15-952-202	20-906-267	29-898-307

14.9.1. Charge Out (Outguide) System. All Health records removed from the Health record department must be replaced by an Outguide containing the following information:

XDetainees Name
XAlien #
XDate record removed from file
XName of person receiving the record

14.9.2. Color Coding. The last three digits are color coded and labeled on the side of the record. The bottom number should be positioned approximately 2 inches from the bottom edge of the folder.

14.10. Forms. Forms developed at the local level are NOT authorized for inclusion in the standard uniform DIHS health record unless prior approval has been received from Headquarters, DIHS.

The following are forms currently approved for use in the DIHS:

DIHS	001	Encounter Form	
DIHS	002	Mass influx Detainee health record card	
DIHS	075	Pre & Post HIV Test Counseling/Consent Form	
DIHS	793	Medical Consent	
DIHS	794	In-Processing Health Screening	
DIHS	795	History and Physical Examination	
DIHS	802	Body Diagram	
DIHS	812	Treatment Authorization & Consultation	
DIHS	819	Detainee Special Needs	
DIHS	820	Refusal Form	
DIHS	834	Medical/Psychiatric Alert	
DIHS	835	Suicide Observation Checklist	
DIHS	835A	Post suicidal observation report	
DIHS	836	Input/Output Flow Sheet	
DIHS	837	Infirmary Admission & Discharge Form	
DIHS	837A	Infirmary Discharge Summary	
DIHS	838	Generic Infirmary Flow Sheet	
DIHS	839	Hunger Strike Monitoring	
DIHS	840	Medication Profile	
DIHS	841	Detainee Medical Status	
DIHS	842	Chronic Disease Flow Sheet	(Diabetes)
DIHS	842A	"	(Seizure Disorder)
DIHS	842B	"	(Tuberculosis)
DIHS	842C	"	(Hypertension)
DIHS	842D	"	(Asthma)
DIHS	842E	"	(AIDS/HIV)
DIHS	842F	"	(Generic)
DIHS	842G	"	(Mental Health)
DIHS	842H	"	(Hypercholesterolemia)
DIHS	843	Mental Health Screening	(English)
DIHS	843A	Chronic Disease Flow Sheet	(Creole)
DIHS	843B	"	(Spanish)
DIHS	843C	"	(Chinese)

DIHS	844A-1	Consent to Use Tricyclic Antidepressant Medication
DIHS	844B-1	" Atypical Antipsychotic Medication
DIHS	844C-1	" Benzodiazepines
DIHS	844D-1	" Lithium
DIHS	844E	" MAOI Antidepressant
DIHS	844G-1	" Miscellaneous Antidepressant Medication
DIHS	844I	" Serotonin Reuptake Inhibitor
DIHS	844J	" mood-stabilizing medication.
DIHS	844K-1	" Buspirone
DIHS	845	Juvenile Transfer Summary
DIHS	846	Prenatal Care History & Physical Exam
DIHS	847	Injury Assessment Form
DIHS	851	Pediatric Physical Assessment – 2 to 4 weeks
DIHS	852	Pediatric Physical Assessment – 2 months
DIHS	853	Pediatric Physical Assessment – 4 months
DIHS	854	Pediatric Physical Assessment – 6 months
DIHS	855	Pediatric Physical Assessment – 9 months
DIHS	856	Pediatric Physical Assessment – 12 months
DIHS	857	Pediatric Physical Assessment – 15 months
DIHS	858	Pediatric Physical Assessment – 18 to 23 months
DIHS	859	Pediatric Physical Assessment – 2 years
DIHS	860	Pediatric Physical Assessment – 3 years
DIHS	861	Pediatric Physical Assessment – 4 years
DIHS	862	Pediatric Physical Assessment – 5 years
DIHS	863	Pediatric Physical Assessment – 6 years
DIHS	864	Pediatric Physical Assessment – 7 years
DIHS	865	Pediatric Physical Assessment – 8 years
DIHS	866	Pediatric Physical Assessment – 10 years
DIHS	867	Post Restraints Observation Report
DIHS	869	Medical Observation of Detainee in Restraints
BOP	s620.060	Problem List
CIPS Form		Medical Admission Record.
USM	553	Medical Summary of Federal Prisoner/Alien in transport
G	639	Freedom of Information/Privacy Act Request
SF	510	Nursing Note
SF	511	Vital Signs Record
SF	519	Radiologic Consultation Request/Report
SF	519A	Radiologic Consultation Request Report
SF	522	Request for Administration of Anesthesia and for Performance of Operations and Other Procedures
SF	545	Laboratory Report Display
SF	600	Chronological Record of Medical Care
SF	601	Immunization Record
SF	603	Dental Record
SF	603A	Dental Record Continuation
SF	608	Dental

14.11. Assembly of Record. All sections of a health record will be filed in the following format in reverse chronological order.

LEFT SIDE OF OPENED HEALTH RECORD

BPs	620.060	Problem List	
DIHS	841	Detainee Medical Status	
DIHS	842	Chronic Disease Flow Sheet	(Diabetes)
DIHS	842A	"	(Seizure Disorder)
DIHS	842B	"	(Tuberculosis)
DIHS	842C	"	(Hypertension)
DIHS	842D	"	(Asthma)
DIHS	842E	"	(HIV/AIDS)
DIHS	840	Health Care Program Medication Profile	
HRSA	408	Medication Administration Record	
DIHS	834	Medical/Psychiatric Alert	
DIHS	835	Suicide Observation Checklist	

Administrative Records:

DIHS	793	Medical Consent Form
SF	522	Request for Administration of Anesthesia and for Performance of Operations and Other Procedures
DIHS	847	Injury Assessment Form

All Other Consent Forms including **psychotropic drug consents DIHS 844s:**

DIHS	820	Refusal Form
G	639	Freedom of Information/Privacy Act Request
DIHS	075	Pre and Post HIV Test Counseling and Consent
USM	553	Inmate Transfer Summary Form

RIGHT SIDE OF RECORD

SF	600	Chronological Record of Medical Care
DIHS	812	Treatment, Authorization & Consultation Form (file in reverse chronological order behind the progress note)

Database

DIHS	794	In-Processing Screening Form
DIHS	795	History & Physical Examination
DIHS	601	Immunization Record
DIHS	846	Prenatal Care History & Physical Exam
DIHS	802	Body Diagram
DIHS	819	Detainee Special Needs

Laboratory

SF	545	Laboratory Report Display (when needed)

Reports from outside labs
Reports from onsite lab work

Radiology

SF	519	Radiographic Reports Backing Sheet

Reports from outside provider(s)
EKG and related (X-Ray & EKG)

Consultations/Other Reports

SF	603	Dental Record
SF	603A	Dental Record Continuation
DIHS	837	Infirmary Admission and Discharge From
DIHS	843	Mental Health Screening (English/Spanish/Creole)
DIHS	849	Hunger Strike Monitoring

Short Stay Unit Record
Summaries/Old Records
Offsite hospitalizations
Records transferred from other facilities

14.12. Transfer of Health Records. The original health record of the detainee shall be transferred with the detainee when the transfer is to another DIHS health services facility.

14.12.1. Transfer of Detainee within DIHS. The original health record will be place in an envelope, sealed and outside labeled "MEDICAL CONFIDENTIAL" and will be given to the INS official responsible for the transfer of the detainee. The Detention Management Information System will be updated to reflect the release date of the detainee from the facility.

14.12.2. Transfer of Detainee outside the DIHS System. A Transfer Summary USM- 533 will be completed which will assist the receiving health care facility to provide continued care for the detainee. The Detention Medical Information System (DMIS) will be updated to reflect the release date of the detainee.

14.13. Labels. The only labels, if applicable, that require placement on the front of the health record include the following:

1. "Allergic to:_____" (centered beneath DIHS heading)
2. "Advance Directive on File" (centered below DIHS heading and allergy label, if applicable).

14.14. Health Record Completion. The timely completion of the health record is of critical importance. The Health Records Administrator and his/her designees assure that each record is complete prior to re filing. In the event a record is incomplete, due to death, resignation, termination, or incapacitation of the provider it shall be given to the Clinical Director or if he/she is the person who is no longer available the DIHS Medical Director will determine if some other Physician on staff can complete the record. If the record cannot be completed by another physician a filed “incomplete” form is

to be locally produced, completed, and signed by the facility health authority and health records supervisor and attached to the front of the health record prior to filing.

14.14.1. Health Record Analysis. The SPC medical facility depends on Health Information Service to analyze health record documentation and notify them of omissions and inconsistencies. There are three types of documentation analysis that the Health Information Service performs on the health record. The first two types of analysis focus on reviews of the documentation in the health records which is to assist health care providers in improving their documentation practices.

14.14.1.1. Quantitative Analysis: This type of analysis is performed to identify areas of the health record that are incomplete, such as a missing lab or x-ray report. Quantitative analysis is the most commonly used approach to identify deficiencies in health record documentation.

Example: "All entries are to be dated and signed." The result of this analysis is the generation of a deficiency list.

14.14.1.1.1. Basic components of Quantitative Analysis:

X Correct patient identification on every form
X Presence of necessary reports
X Required authentication of all entries
X Good recording practices, i.e. Errors corrected according to policy; entries on SF-600 use of the SOAP format

14.14.1.2. Qualitative Analysis: This type of analysis is used to identify inconsistent or inaccurate documentation. The Health Information staff applies knowledge of diverse processes, policies and standards of the clinic and licensing and accrediting agency standards to analyze health record documentation.

14.14.1.2.1. Basic components for Qualitative analysis:

X Complete and consistent recording of diagnostic statements
X Consistency in entries
X Recording of all necessary instance of informed consent
X Application of good documentation practices
X Occurrences of a potential risk management incident

Some examples are as follows:

X A positive PPD result documented on the SF-600 but not recorded on the Problem list
X Terms left and right or male and female have been interchanged in a health record
X Identification of inconsistencies and omissions that may potentially be incomplete or inaccurate, i.e., a bone fracture recorded but no order for X-ray included in the note.

14.14.1.2.2. Skill Requirements. In order for this type of analysis to be performed, the Health Information Personnel is to have a knowledge of medical terminology, anatomy and

physiology, fundamentals of disease processes, health record content, and the standards of NCCHC, ACA, and JCAHO. This level of review is usually performed by a RHIT or RHIA.

14.14.1.2.3. Purpose. The qualitative analysis purpose is to ensure that the health record is complete for reflecting patient care, protect legal interests, meet standards and for accurate data and statistical analysis.

14.14.1.3. Statistical Analysis: This involves abstracting data from health records for administrative and clinical decision making.

Example: Entering data into the automated health information system, coded and other data is entered according to organization requirements. This type of analysis uses classification systems.

14.15. Filing of Inactive Records. When records are transferred from active to inactive status a **month and year** label reflecting the inactive date is attached to the upper section of the folder's back edge. Inactive records should be separated in the file by month and year. Within each month/year section records are filed by terminal digit order.

14.16. Retention of Records. Health records will be retained on file at the Health Services Unit for three years. At the end of the three years, the detainee(s) record will be destroyed.

14.17. Short Stay Unit Records (SSU). A separate health record is maintained while the patient is admitted to the SSU. Upon discharge from the SSU the record will be included in the detainee's outpatient chart with a divider indicating "Short Stay Unit".

14.17.1. Outpatient observation. This is considered short duration, less than 24 hours. A patient placed into the SSU for up to 24 hours will not be considered an admission into the SSU. If observation extends beyond 24 hours the patient will be considered an admission and an order will be written on the SF-600 by the Clinical Director or another provider. When a patient is admitted following observation, the provider should inform the Health Information Service. Patients may not be reclassified as observation once a decision to admit the patient has been determined.

14.17.2. Outpatient Documentation. For outpatient observation patients, the provider, at a minimum, is responsible for the following:

- X Written order for "outpatient observation status" on the SF-600.
- X Completion of a History and Physical.
- X Progress notes to support care past initial evaluation.
- X Written discharge note and discharge instructions on the SF-600 and PIHS 837.

14.17.3. Chart Assembly for Short Stay Unit (SSU). The short stay record shall be divided into the following sections:

Administrative Record
Consents
Admission Record

Discharge Summary
Physical Exam
Physicians Orders
Progress Notes
Laboratory Reports
Imaging Reports
Consultation Reports